CHANDLER POLICE DEPARTMENT

REQUEST FOR MEDICAL RECORDS – DOMESTIC VIOLENCE VICTIMS
(CFR § 164.512)

Patient: _____

Patient Date of Birth: _____ Patient SS# if known: _____-____-____

Name of Provider: _____

Date of Treatment: _____

Chandler Police Department, 250 East Chicago Street, Chandler, Arizona OR #: _____

The undersigned member of the Agency noted above, states that:

- I am a peace officer in the State of Arizona and am conducting an active domestic violence investigation.
- The named patient is a suspected victim of domestic violence, and the patient's records are needed to prosecute the domestic violence charges.
- I, or another authorized person has tried and have been unable to obtain the patient's authorization to release the patient's medical records.
- I am seeking only the minimum amount of patient information the Agency needs for the investigation. The release of this information is authorized under HIPPA pursuant to CFR § 164.512.

_____ _____
Printed name of Officer / Detective Title

_____ _____
Signed name of Officer / Detective Date

For hospital personnel to document verification of officer's identity

_____ Badge number and Chandler Police Identification verified: Badge #: _____

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